

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039903

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 516 Primary Registration District No. 3061 Registrar's No. 453

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1962	
1. PLACE OF DEATH a. COUNTY <u>St. FRANCOIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FLAT RIVER, MO.</u> Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. FRANCOIS</u> c. CITY OR TOWN <u>FLAT RIVER, MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>A.</u> Last <u>KORWINE</u>	
4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 28, 1886</u>
9. AGE (last birthday) <u>75</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE - WIFE</u>
11. BIRTHPLACE (City and state or country) <u>NEAR WARRENBURG, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Christopher</u>	13b. MOTHER'S MAIDEN NAME <u>ELEANOR. SAMS</u>
14. NAME OF HUSBAND OR WIFE <u>EDGAR KORWINE (DEPT)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NA</u>	16. SOCIAL SECURITY NO. <u>NONE</u>
17. INFORMANT <u>MRS HAROLD BOYD</u> Address <u>FLAT RIVER, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>10-25-62</u> , to <u>10-25-62</u> and last saw her alive on <u>10-25-62</u> Death occurred at <u>7:45 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>C.E. Towell, D.O.</u>	22b. ADDRESS <u>FLAT RIVER, MO.</u>
22c. DATE SIGNED <u>10-26-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/28/62</u>
23c. NAME OF CEMETERY OR ORGANIZATION <u>ST. FRANCOIS MEM PARK.</u>	
23d. LOCATION (City, town, or county) (State) <u>Bonne Terre MO.</u>	
24. FUNERAL DIRECTOR <u>R. K. Aldwell</u> ADDRESS <u>11250N'S FLAT RIVER MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 26, 1962</u>
26. REGISTRAR'S SIGNATURE <u>Arthur Rudloff</u>	

DR. HOWE
 VS 300
 Rev. 4/59
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

NOV 14 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Donald Dale Caldwell

Licensed Embalmer No.

5095

P. O. Address

Flat River, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.